	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MH 7101 E	E CONSTRUCTION TO THE LAND CONSTRUCTION TO THE	OMB NO. 0938-0391 DATE SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		OMPLETED
		345286	B. WING		05/19/2012
NAME OF P	ROVIDER OR SUPPLIER		STREE	ET ADDRESS, CITY, STATE, ZIP CODE ()	00/10/2012
SALISBU	RY CENTER		ŀ	JULIAN ROAD LISBURY, NG 28147	
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F 279 SS≐D	COMPREHENSIVE)(1) DEVELOP CARE PLANS ne results of the assessment	F 279	•	
	to develop, review a comprehensive plan. The facility must develop plan for each reside objectives and timet medical, nursing, an needs that are identical assessment. The care plan must to be furnished to all highest practicable posychosocial well-be §483.25; and any se be required under §4 due to the resident's	nd revise the resident's of care. I color a comprehensive care not that includes measurable ables to meet a resident's domental and psychosocial lifed in the comprehensive describe the services that are tain or maintain the resident's physical, mental, and ping as required under revices that would otherwise 183.25 but are not provided exercise of rights under the right to refuse treatment.		Resident #64 no longer resides in the center. An audit was completed of current resident care plans with aggressive behaviors and they were reviewed and updated as needed at point or discovery by Social Worker on 5/18/2012. Education of the licensed nurses was provided on 5/18	
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to update a care plan for a resident who had repeated aggressive behaviors towards other residents for 1 of 1 cognitively impaired resident's with behaviors (Resident #64). Findings include: Resident #64 was admitted on 3/3/12 with diagnoses including Dementia, Diabetes Type II and hypertension.			19/2012 by Director of Nursing regarding placing residents with aggressive behavior on 1:1, notification of physician, referral to recreation director for further interventions, use of the behavior monitoring tool and updating care plans with new interventions.	
OPATANA	DEOTORIO OF				,
ALANGO D	PEOTOKS OK PROVIDERK	SUPPLIER REPRESENTATIVE'S SIGNATURE	IIO	ATITLE / /	20.25

WIND WAY

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2NQS11

Facility ID: 923354

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
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	(MDS) assessment of Resident #64 had shiproblems and was midecision making. He physical, verbal and others. The behavior the resident or others were identified as integrated and participation the privacy of others environment. Wander identified and the residentified and the resident were heard yelling at were observed kicking indicated the incident Assistant who stated the altercation. The intervention were: - allow resident time to approach in calm frienessess and manage document interventions	sion Minimum Data Set ated 5/10/12 revealed ort and long term memory oderately impaired in was also coded as having other behaviors towards at physical risk of injury but effering with the resident 's in activities, intruding on and disrupting the living wing behaviors were also ident was assessed as able of the second of	F 279	Director of Nursin will conduct roun identify any resid aggressive\inappr behaviors across daily for 30 days times a week acroshifts for 30 days corrective action discovery. Findin reported to the Ac Any trends identification and the Correction of the Correction o	ent with copriate all 3 shifts and than 3 with at point of gs will be laministrator.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SU COMPLET	
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	3/13/12 at 11:19 AM of 3/10/12 was summari interventions were idea. A Care Plan Meeting 11:21 AM revealed the discussed as well as and combative behavidentified was "SW (on placement." A Care Plan Evaluation 3:03 PM revealed "VW anders in/out of rooredirected per staff." identified. On 3/17/12 at 9 PM a revealed Resident #6 room mate (Resident #6 room mate (Resident #6 room for the separate rooms for the comparate rooms for the comparate rooms for the comparate rooms for the comparate rooms for the resident #173 was signored at the incident. Review of the Care Please and the comparate rooms for the comparate rooms for the resident #173 had a comparate rooms for the resident #174 had a comparate rooms for the resident #175 had a comparate rooms for the resi	lan Evaluation note dated revealed the incident on zed in the note. No entified. Late Note dated 3/13/12 at e incident on 3/10/12 was the resident's exit seeking ior. The intervention Social Worker) is working on note dated 3/14/12 at Vander guard continues. ms and facility, constantly No new interventions were Change of Condition report 4 was observed hitting his #173) with a balled up e Incident Reports dated #64 and Resident #173 ion was have them sleep in e night. oted) Incident Reports for sident #173 revealed ting in his wheelchair in his and his room mate Resident	F 279			

1	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SU COMPLET	
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F 279	3/18/12 was summari interventions were ide Review of the Care Pi 3/21/12 at 8:15 AM re 3/17/12 and 3/18/12 rd discussed. The note #64, had wandering b leave the facility and winterventions discussed was being assessed f and a room change w was then moved to a Hall). On 3/22/12 at 2:50 PM report revealed Resid Resident #139. Revied at day 22/12 for Res #139 revealed that Re #139 a "black boy" upset Resident #139, including Mental Reta #64. The bite drew bliftinger of resident #64. Review of the Care Pl 3/26/12 at 1:23 PM re 3/22/12 was summariz interventions were ide Review of the nursing PM revealed "This pt hall and another patient something to him and other patient hit him in noted. Both patients v	zed in the note. No new entified. Ian Meeting Notes dated vealed the incidents on toted above were also indicated that Resident ehaviors, attempted to was not easily directed. The ed were that Resident #64 or locked unit placement as suggested. Resident #64 room on 200 Hall (from 100) If a Change of Condition ent #64 was bitten by ew of the Incident Reports ident #64 and Resident (racial comment). This slur who had diagnoses redation, and he bit Resident ood from the left middle an Evaluation note dated wealed the incident on zed in the note. No new	F 279			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SU COMPLE	
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F 279	this incident was not was not identified. Review of the Care P 3/27/12 at 11:15 AM 3/26/12 was summar new interventions we interventions listed w redirect and seek pla The 4/6/12 Physician revealed an order to bathroom upon rising bedtime and as need urinating on the carperevealed this interver care plan. On 4/10/12 at 2:37 P report revealed Resid the face. When asked he said he did not additional intervention Works (a behavioral consult, medications recommendations, care-evaluation. " Review of the 4/11/1: Meeting notes reveal discussed in the Intervention the Indicated Remergency Department was not admitted with no new orders, the Physician had do Reduction of Resider	Plan Evaluation note dated revealed the incident on ized in the note and that no re identified. The ere: "cont (continue) to cement on locked unit." I's Telephone Orders take Resident #64 to the perior and after meals, at led to prevent him from et. Review of the care plan intion was not listed in the M a Change of Condition dent #64 hit Resident #173 in dwhy he hit Resident #173 in dwhy he hit Resident #173 look good. "Under in it read "called to Life health services company) for decreased per pharmacy alled physician for 2 11:41 AM Care Plan led Resident #64 was rdisciplinary Team meeting. esident #64 was sent to the ent on 4/10/12 as ordered and returned to the facility The note also indicated that	F 279			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		ONSTRUCTION	(X3) DATE S COMPLI	
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F 279	(medications) d/t (du Review of the Care 4/11/12 at 11:43 AM information as noted Care Plan Meeting r On 4/21/11 at 5 PM revealed that Reside #173 from behind the read, in part, " combit this pt (patient) target consistently." The was to separate the On 4/25/12 at 8:15 Freport revealed " Nu hand off walker becafrom room mate agasthe room mate, Resident #64 to get then Resident #173, grab it back and was cursidering this incident, implemented at this	Doctor) to re-evaluate meds the to) aggressive behavior. Plan Evaluation note dated revealed the same I in the 4/11/12 11:41 AM note. A Change of Condition report the the fead and pulled. The note pative behavior continues with resident the head and pulled. The note pative behavior continues with residents. PM a Change of Condition the residents. PM a Change of Condition the residents. PM a Change of Condition the resident that dent #241, had asked off Resident #241 's bed and the walker at Resident the walker at Resident the walker at Resident the resident that date and gave an order for ligram) now. PM a Change of Condition dent #64 walked up behind bed his right arm and pulled ing and verbally threatening	F 2	79			

months are considerable and parameters.

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OFINITIA	O I OI WILDIOANL Q	INCDIO NO OLIVIOLO	1				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 279	nurse contacted the Stime and was told to hospital to see if a be nurse called she was available but Resider Under additional interest to RP about Alzheims Review of the Care P5/7/12 at 9:36 AM review as summarized in the new interventions. Treiterated were: "wo behavioral center and Will continue to moni Review of the Physic 5/8/12 revealed "Alzlabs, needs alternative with SW, nurse report behavior." Review of the laboratic collected on 5/9/12 reverse within normal liming On 5/11/12 at 2:06 Pin Resident #64 drew be (unnamed) but staff in incident reports for the Resident #64 was coon the floor and going the staff of the property of the province on the floor and going the staff of the province of the floor and going the staff of the province of the floor and going the staff of the province of the floor and going the staff of the province of the floor and going the province of the floor and going the floor and going the province of the province of the floor and going the province of the province of the floor and going the province of the province	Social Worker (SW) at this call the behavior unit at the did was available. When the told there was a bed at #64 was not a candidate, eventions it read "SW to talk er unit placement 5/7/12. Plan Evaluation note dated evaled the incident on 5/6/12 me note and there were no the interventions that were writing on placement at dino new beds available, tor and redirect as needed." Jian's Progress Note dated theimer dementia, will check replacement, will discuss its pt continues with agitated thory results dated as evealed the CBC and CMP mits. Change note revealed the red to 300 hall. M a nursing note revealed ack to hit another resident intervened. There were no	L	279			

ETEROTORISM CONTROL CO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/05/2012

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	alone. Pt goes to his to get to his old room and there are other pi confused since room (lorazepam) given in a confused since room (lorazepam) given in a confused since room (lorazepam) given in a confused they are 'scared'. It several times half dre notified and lorazepar to assist. On 5/15/12 at 7:45 PM report revealed Resid #173. Resident #64 v and then slammed a confused a staff member. The staff reports pt exhibite "Pt then observed seinappropriately and in staff members." The Physician's Telep revealed an order for 1 (no route specified). If Administration Record lorazepam 0.5 mg was On 5/15/12 at 9:30 PM Resident 's behavior of monitor pt 1:1. Repeat	et out of here and leave that old room on 200 hall trying to lay down to go to sleep. In that room. Pt. real change." "IM Ativan ight deltoid." "M a nursing note revealed mbative with staff and of resident rooms. The note residents telling this nurse has come up the hall ssed." The physician was in IM was given with 3 staff. "A a Change of Condition ent #64 smacked Resident roas removed from the area floor that caught the foot of note also read, in part, "end exit seeking behavior." read exit seeking behavior. "read exit seeking b	F	279			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		ONSTRUCTION	(X3) DATE SI COMPLE	
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F 279	revealed that she use when Resident #64 w residents or go in other residents are ever plate stated that they do not have done it for reside ideation. Nurse #1 and call the family to come and sometimes familied. Interview with the Actin Administrative Staff # aware of Resident #64 and that room change had been initiated to the behaviors. Administrative were seeking lock Resident #64 as he with facility and they had to the hospital but he was rebeing admitted. He all doing all they could are any injuries from the in #64. Interview with Administrative with Admin	ehaviors noted. " If on 5/17/12 at 3:30 PM deredirection to intervene ould approach other er rooms. When asked if ced on 1:1 observation she to have staffing for 1:1 but ents who have suicidal lided that sometimes they eand sit with the resident es pay for a sitter. Ing Administrator and a revealed that they were the saggressive behaviors is and medication changes between the staff #1 indicated that ked unit placement for as not appropriate for the lied to send him to the turned to the facility without so said that they were and that there had not been incidents involving Resident It was difficult to predict is sive behavior as it was and how Resident #173 and being protected from the lied to the stated they it in the staff would me and stay with him.	F	279			

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STREET ADDRESS, CITY, STATE, ZIP CODE TO JULIAN ROAD SALISBURY CENTER STREET ADDRESS, CITY, STATE, ZIP CODE TO JULIAN ROAD SALISBURY, NC 28147		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUR COMPLET	
SALISBURY CENTER TO JULIAN ROAD SALISBURY, NC 29147 SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 279 Continued From page 9 interventions they had tried were medication changes and they were seeking alternate placement. She indicated that alternate placement on a locked unit would be most appropriate for Resident #64 and would protect the other residents. Administrative Nurse #1 denied being aware of any resident 's being scared of Resident #64 and stated he was on a tolieting program and closely monitored to manage his behavior. Interview with the Social Worker (SW) on 5/18/12 at 1:30 PM revealed that room changes had been done to protect other residents. She did not know why Resident #64 was still in a semi-private room and continued to have room mates despite his history of having aggressive incidents with room mates. When it was pointed out that Resident #173 had been attacked 6 times she acknowledged this was still occurring and that was one of the reasons they were seeking alternate placement for Resident #64. She said			345286	B. WIN	G		05/1	9/2012
FREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 279 Continued From page 9 interventions they had tried were medication changes and they were seeking alternate placement. She indicated that alternate placement on a locked unit would be most appropriate for Resident #64 and would protect the other residents. Administrative Nurse #1 denied being aware of any resident's being scared of Resident #64 and stated he was on a toileting program and closely monitored to manage his behavior. Interview with the Social Worker (SW) on 5/18/12 at 1:30 PM revealed that room changes had been done to protect other residents. She did not know why Resident #64 was still in a semi-private room and continued to have room mates despite his history of having aggressive incidents with room mates. When it was pointed out that Resident #173 had been attacked 6 times she acknowledged this was still occurring and that was one of the reasons they were seeking alternate placement for Resident #64. She said					7	10 JULIAN ROAD		
interventions they had tried were medication changes and they were seeking alternate placement. She indicated that alternate placement on a locked unit would be most appropriate for Resident #64 and would protect the other residents. Administrative Nurse #1 denied being aware of any resident 's being scared of Resident #64 and stated he was on a toileting program and closely monitored to manage his behavior. Interview with the Social Worker (SW) on 5/18/12 at 1:30 PM revealed that room changes had been done to protect other residents. She did not know why Resident #64 was still in a semi-private room and continued to have room mates despite his history of having aggressive incidents with room mates. When it was pointed out that Resident #173 had been attacked 6 times she acknowledged this was still occurring and that was one of the reasons they were seeking alternate placement for Resident #64. She said	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETION
Resident # 64. She acknowledged that in the meantime the facility was responsible to protect other residents but she did not know what other interventions could be added beyond what was already being done. F 323 SS=K HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	interventions they had changes and they we placement. She indicated placement on a locked appropriate for Residents. Adenied being aware of scared of Resident #6 toileting program and manage his behavior. Interview with the Sociat 1:30 PM revealed to done to protect other why Resident #64 was and continued to have history of having aggrantes. When it was part #173 had been attack acknowledged this was one of the reason alternate placement for that at this time she had Resident #64. She a meantime the facility wother residents but she interventions could be already being done. 483.25(h) FREE OF A HAZARDS/SUPERVIST The facility must ensure environment remains as is possible; and ear adequate supervision.	It fried were medication re seeking alternate ated that alternate d unit would be most ent #64 and would protect Administrative Nurse #1 f any resident 's being 34 and stated he was on a closely monitored to clail Worker (SW) on 5/18/12 hat room changes had been residents. She did not know a still in a semi-private room a room mates despite his residents with room cointed out that Resident red 6 times she as still occurring and that has they were seeking for Resident #64. She said and no discharge options for cknowledged that in the was responsible to protect re did not know what other readded beyond what was accident signal for services re that the resident as free of accident hazards ch resident receives					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	<u>. 0938-0391</u>
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F 323	Continued From page	10	F	323	F323		
	by: Based on record reviresident interview the effective interventions resident to resident pleognitively impaired rebehaviors (Resident #Findings include: Immediate Jeopardy when Resident #64 w roommate, Resident #173 on 3/1 room change was init aggression against Rattacks against reside of aggression against Rattacks against reside of aggression against #241. Interventions or redirection, room changes but were insacts of aggression an aresidents. The Administrator was Jeopardy on 5/18/12. Immediate Jeopardy 12:10 PM after the Cravalidated through stat and observations. The compliance at a scopisolated deficiency the with potential for more	hysical aggression for 1 of 1 esident's with aggressive #64). began on 3/17/12 at 9 PM ras observed hitting his #173, with a balled up ently hit his roommate 8/12 at 5:50 PM before a iated. There was one act of esident #139, four more ent #173 as well as one act a new room mate, Resident locumented included inges and medication ufficient to prevent repeated d attacks on other			Resident #64 no longer resides in the center. An audit was completed to identified residents who was demonstrating aggressive behaviors and this was completed on 5/19/12 by DON/Designee. No other residents were identified at the time of the audit.	vere	6/19/2012

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 323	policies and procedur facility could be review Quality Assurance Co also in the process of the employee training Resident #64 was addiagnoses including E and hypertension. Sordered on admission (milligrams) daily Zold Namenda 5 mg twice symptoms of dementia bedtime (used to treat dementia), Ativan (lor (an anti-anxiety media three times a day (a soften used to treat madisorders), trazadone insomnia (an antidept Review of the Physici dated 3/4/12 revealed AM dose of Namendamg (milligrams) every an order for check was shift. The 3/7/12 9:20 PM r Resident #64 had be stripped off his clothe threatening staff. Realert to name. The in constant redirection. by leaving a message the Responsible Party	es implemented by the wed and evaluated by the semmittee. The facility was ensuring the completion of	F	323	Dementia specialist wa consulted on 5/18/12 fe education regarding rewith aggressive behaviors of page aggressive behaviors of 5/18/12 at 11:50am. Administrative, direct and ancillary staff were immediately educated Director of Nursing/de on 5/19/12 and continueducated as needed and appropriate. Residents identified as demonstrated as demonstrated as demonstrated as identified as ide	or sidents ors. ors. ors. ors. ors. ors. ors. ors	

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) DATE SUI	
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F 323	(MDS) assessment do Resident #64 had sho problems and was modecision making. He physical, verbal and cothers. The behavior the resident or others were identified as integrated as integ	ated 5/10/12 revealed of and long term memory oderately impaired in was also coded as having ther behaviors towards as were not considered to put at physical risk of injury but refering with the resident's in activities, intruding on and disrupting the living ring behaviors were also also revealed that Resident with most activities of daily red extensive assistance of toileting and personal uired set up assistance to MDS Resident #64 was and transferring and had no tions. If a Change of Condition ent #64 and Resident #139 each other on 200 hall and peach other. The note also was observed by a Nursing hat Resident #64 initiated attervention was to redirect ng down 200 hall while to in the hallway. The by leaving a message in	F	323	director/designee for intervention upon discove Director of Nursing/design will implement physician medication and/or non-pharmacological interventions at the time to orders are received. A monitoring tool for aggressive/inappropriate behaviors was developed 5/18/12. This tool include observations for behavior triggers for the behavior ainterventions. An audit we completed by the Director Nursing/Designee on resicare plans for all residents who had documented behaviors on 5/18/2012. Vecorrective actions added to care plans as appropriate during the audit process.	on es and as r of dent s	

STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S COMPLE	
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F 323	Review of the Care F behavior care plan w episodes (of behavio interventions were: -allow resident time t -approach in calm friassess and manage -document interventiencourage resident and adjust time spen span/tolerance -listen to resident ne appropriate -listen to resident an On 3/17/12 at 9 PM revealed Resident # room mate (Resident blanket. The physic message in the Doc notified. Review of t 3/17/12 for Resident revealed no injuries and that the interven separate rooms for t On 3/18/12 at 5:50 F report revealed Resi Condition behaviors incident were preser notified but there wa RP was notified. Re for Resident #64 and Resident #173 was room eating supper #64 hit him on the ri	Plan dated 3/13/12 revealed a ith a goal of not more than 3 rs) a week. The o vent feelings/needs endly manner unmet needs ons and resident response to attend activities of choice at to resident attention eds and adjust plan as d try to calm a Change of Condition report 34 was observed hitting his t #173) with a balled up ian was notified by leaving a cors in-box and the RP was he Incident Reports dated #64 and Resident #173 occurred during this incident tition was have them sleep in	F 323	Director of Nursing/o will conduct rounds to identify any aggressive/inapproprise behaviors across all 3 daily x 30 days and to times per week across shifts x 30 days. Interdisciplinary team discuss/address all be and interventions implemented with effectiveness weekly customer at risk mee. Findings will be reported the Quality Improver Committee for review trends and additional items as needed x 90.	iate 3 shifts hen 3 s all 3 m will ehaviors with tings. orted to ment v of action	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER			71	EET ADDRESS, CITY, STATE, ZIP CODE 10 JULIAN ROAD ALISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X6) COMPLETION DATE
F 323	dated 3/18/12 (no time to increase Zoloft to 1 decrease agitation. The telephone but there were was notified. Reverse as a continuation of the Care Pay 1/12 revealed the 3/18/12. Review of the Care Pay 1/12 revealed the 3/18/12 noted above also indicated that Resident are that Resident #6 locked unit placement suggested. Resident room on 200 hall (from Con 3/22/12 at 2:50 Preport revealed Resident #139. The practitioner were notified interventions reference Physician's Telephonorders from 3/18/12 to Incident Reports date and Resident #139 recalled Resident #139 recal	an's Telephone Orders e noted) revealed an order 50 mg every day to the physician was notified by ras no notation indicating the riew of the Medication d for 3/18/12 revealed the 0 mg was given at 8 PM on lan Meeting Notes dated incidents on 3/17/12 and were discussed. The note esident #64, had wandering to leave the facility and was he interventions discussed by was being assessed for and a room change was #64 was then moved to a m 100 hall). If a Change of Condition ent #64 was bitten by officed and the RP was notified. Fired to a new order but the fied and the	F	323			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
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F 323	revealed an order to colorazepam dose to 0.2 decrease the 8 PM lost then on 4/15/12 to dis lorazepam dose and of the 8 PM lorazepam dose and of the 8 PM lorazepam of the 4/6/12 Physician's revealed an order to the bathroom upon rising, bedtime and as neede urinating on the carpe of the face. When asked the face when asked the face of the differential intermediation of the said " he did not loraze and the said " he did not loraze and the said " he did not loraze and the said " he s	decrease the 8 AM 25 mg then on 4/8/12 to razepam dose to 0.25 mg, scontinue the 8 AM on 4/22/12 to discontinue dose. Is Telephone Orders take Resident #64 to the to before and after meals, at ed to prevent him from the first first the first first the first first the first fir	F 32	23		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
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F 323	with no new orders. The Physician had dol Reduction of Residen medications (lorazepa will get MD (Medical I (medications) d/t (due On 4/21/11 at 5 PM a revealed that Resider #173 from behind the read, in part, " combatins pt (patient) target consistently. " The ir was to separate the rewas notified by leavin in-box and the RP wa Incident Reports for F#173 revealed no injuthis incident. On 4/25/12 at 8:15 Pl report revealed " Nur hand off walker becaut from room mate again the room mate, Resident #64 to get othen Resident #64 to get othen Resident #64 thr #241, but it did not hit taken down the hall b was notified and the pan order for lorazepar Incident Reports date and Resident #241 re injuries as a result of The Physician's Teleprevealed an order for	The note also indicated that the a Gradual Dose at #64's anti-anxiety arm) and revealed the plan "Doctor) to re-evaluate meds at to) aggressive behavior. Change of Condition report at #64 grabbed Resident head and pulled. The note ative behavior continues with ing other res (resident) intervention for this incident esidents. The physician g a message in the Doctors is notified. Review of the Resident #64 and Resident intervention for the Resident are a result of the Resident at the tries occurred as a result of the Resident #64 and Resident intervention for this incident are at the was trying to take it in. "It also indicated that the ent #241, had asked if Resident #241's bed and the withe walker at Resident thim. Resident #64 was a systaff at that time. The RP ohysician was notified and may a given. Review of the dd 4/25/12 for Resident #64 wealed there were no	F3	23		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		DINSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 323	Record for 4/25/12 regiven at 8:30 PM. On 5/6/12 at 8:10 PM report revealed Reside Resident #173, grabb it back and was cursidering this incident. Implemented at this tiresidents. In addition nurse contacted the Stime and was told to chospital to see if a be nurse called she was available but Resident The nurse then inform according to the note interventions it read 'Alzheimer unit placen Incident Reports date and Resident #173 reas a result of this incident Review of the Physici 5/8/12 revealed "Alzlabs, needs alternativ with SW, nurse report behavior." The Physician's Teleprevealed the following ordered for the following ordered for the following ended the place of the laborate Review of the laborat	a Change of Condition lent #64 walked up behind lent #64 walked up behind lend his right arm and pulled ling and verbally threatening The intervention lend was to separate the ling, the note revealed the locial Worker (SW) at this leal the behavior unit at the lind was available. When the lotold there was a bed lined the SW and RP linder additional lined was not a candidate. lined the SW and RP linder additional lined to talk to RP about linent 5/7/12. If Review of the linent 5/6/12 for Resident #64 linent services Note dated linent dementia, will check line placement, will discuss list pt continues with agitated linene Orders for 5/8/12 liaboratory work was ling morning: CMP (complete C (complete blood count), SH (Thyroid Stimulating	F	323			

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F 323	resident was transfer Hall. On 5/11/12 at 2:06 Pi Resident #64 drew b (unnamed) but staff i incident reports for the Construction on the floor and going 's rooms and messir Other pt are yelling galone. Pt goes to his to get to his old room and there are other pt confused since room (lorazepam) given in The Physician's Tele revealed an order for mg three times a day and an order for IM (0.5 mg now. Review Administration Record lorazepam was giver Depakote order was The 5/14/12 Physicia revealed an order for Review of the Medicarevealed lorazepam On 5/14/12 at 11:05	Change note revealed the red to 300 h M a nursing note revealed ack to hit another resident intervened. There were no is occurrence. a nursing note revealed imbative with staff, urinating ig in and out of other resident ig with their belongings. " et out of here and leave that old room on 200 Hall trying it to lay down to go to sleep it in that room. Pt. real change. " "IM Ativan right deltoid." chone Orders dated 5/11/12 in decrease Depakote to 125 in (was 250 mg twice a day) intramuscular) lorazepam	F 323			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 323	wandering in and out read, in part, "femal they are 'scared'. several times half dre notified and lorazepa to assist. On 5/15/12 at 7:45 Preport revealed Resid #173. Resident #64 and then slammed a a staff member. The staff reports pt exhibi "Pt then observed se inappropriately and in staff members." The notified and the note received "continued (times) 2 weeks. Zypbe initiated 5/16/12. behavior." Review 5/15/12 for Resident #1 of the head and there of this occurrence." The Physician's Teleprevealed an order for (no route specified). Administration Record lorazepam 0.5 mg was On 5/15/12 at 9:30 P Resident's behavior of monitor pt 1:1. Repemember), asked to vibehaviors. (Family member) is several times and the properties of the second	of resident rooms. The note of residents telling this nurse Has come up the hall essed. "The physician was in IM was given with 3 staff. M a Change of Condition dent #64 smacked Resident was removed from the area door that caught the foot of note also read, in part, "ted exit seeking behavior." everal times placing hands in a sexual manner on various of physician and RP were indicated new orders were observation, Zoloft taper x orexa 5 mg q (every) day to Continue to monitor of the Incident Reports dated #64 and Resident #173 173 was smacked in the back of were no injuries as a result phone Orders dated 5/15/12 plorazepam 0.5 mg now x 1 Review of the Medication d for 5/15/12 revealed IM	F	323			

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F 323	sexually aggressive to the come and visit with the resident #139 founds to try and prevent was because he worked while he resident #139 founds to try and prevent #149 founds to try and prevent #150 founds	M a nursing note revealed andering in and out of exit seeking. M a nursing note revealed directed from multiple ems on 100 Hall due to ident to resident conflicts D Hall. Resident #64 became ed to be redirected but evay. PM a nursing note revealed to his room and picked up his attempted to leave the room s family member was called	F 32			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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SALISBURY CENTER 710 JULIAN ROAD SALISBURY, NC 28147 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE			345286	B. WIN	G		05/19	9/2012
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Resident #64 to stop and he did, but then right before Resident #241 was discharged Resident #241 indicated that the physician was notified of all incidents and incidents were documented as required but review of the Medical Record from 3/3/12 - 5/18/12 revealed no information about either of these incidents. When asked if residents are ever placed on 1:1 observation she stated that they do not have staffing for 1:1 but have done it for residents who have suicidal idealtion. Nurse #1 added that sometimes they call the family to come and sit with the resident and sometimes families pay for a sitter. During interview with resident #173 on 5/17/12 at 5 PM, when asked if anyone had ever hurt him at the facility he indicated he had been hurt and stated that " (name of resident #404) hit me 4 or 5 times." He indicated that he had been hurt. The Acting Administrator and Administrative Staff #1 were informed of the Immediate Jeopardy on 5/18/12 at 10-40 AM. Interview with the Acting Administrative Staff #1 revealed that they were aware of Resident #64's aggressive behaviors and that room changes and medication changes had been initiated to try and manage his behaviors. Administrative Staff #1 indicated that they were seeking locked unit placement for Resident #64 as he was not appropriate for the facility and they had tried to send him to the hospital but he was returned to the facility without being admitted. He also said that they were doing all they could and that there had not been any injuries from the incidents involving Resident #64.	Resident before R #64 defe indicated incidents required 3/3/12 - either of residents stated th have dor ideation. call the f and som During ir 5 PM, with the facility stated th times. " The Actif #1 were 5/18/12 and Administ revealed aggressi medication manage indicated placeme approprisend him the facility that they had not see the second s	nt #64 to stop Resident #241 fecated on Re- ed that the phy ts and inciden d but review o - 5/18/12 reve- of these incide ats are ever pla that they do no one it for resid n. Nurse #1 a- family to com- metimes famili interview with when asked if illity he indicate that "(name of " He indicate that "(name of at 10:40 AM. strator and Ad. but that they we sive behaviors ed that they we sive behaviors did that they we sive behavior ed that they we ent for Reside when to the hosp illity without be every were doing t been any inju-	and he did, but then right was discharged Resident sident #241's bed. Nurse #1 risician was notified of all ts were documented as if the Medical Record from aled no information about ints. When asked if aced on 1:1 observation she of have staffing for 1:1 but ents who have suicidal dded that sometimes they e and sit with the resident ies pay for a sitter. resident #173 on 5/17/12 at anyone had ever hurt him at ed he had been hurt and of resident #64) hit me 4 or 5 d that he had been hurt. ator and Administrative Staff the Immediate Jeopardy on Interview with the Acting ministrative Staff #1 ere aware of Resident #64's and that room changes and had been initiated to try and is. Administrative Staff #1 ere seeking locked unit ent #64 as he was not icility and they had tried to initial but he was returned to initial but he incidents	F	323			

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F 323	On 5/18/12 at 1 PM i Assistant #1 (NA #1) difficult to keep an ey had other residents ther hall who wandere. She stated that she was Resident #64 frequeitaken to the bathroor after breakfast and it on the floor in public. On 5/18/12 at 1:15 Frevealed resident #6 and had hit her, but to occasions during carthat he wandered a looking for him. She would mess around belongings. NA #2 is cursing at Resident #6 comment and also s started kicking Resident #64 " picks on me." seen Resident #64 cshe had never seen Interview with Adminat 1:20 PM revealed Resident #64's aggresporadic. When ask other residents were physical attacks by I tried to have staff me incident happened, a call his family membe Administrative Nurse	nterview with Nursing she stated that it was re on Resident #64 as she to take care of and 2 men on the including Resident #64. would go and look for ntly and make sure he was on on rising, and before and sinch, so he wouldn't urinate places. M interview with NA #2 4 needed constant cueing the including hard, on numerous the or redirection. She stated of and she would have to go also said that Resident #64	F	323			

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F 323	changes and they we placement. She indic placement on a locke appropriate for Resid the other residents. A denied being aware of scared of Resident #6 toileting program and manage his behavior. Interview with Nurse revealed that after Reson 5/6/12, she had be Worker to call to see at the Geriatric Behavior health disorder. Interview with the Sonat 1:30 PM revealed done to protect other pointed out that Resid attacked 6 times she occurring and that wawere seeking alternat #64. She stated that Party had been reluct a locked unit but had two programs had con Resident #64 but in thim. She stated that hospital for evaluation being admitted. The took him back and if they called the state of the pointed to hospital thim back and if they called the state of the placement was the state of the placement was the state of the placement was the placement wa	re seeking alternate ated that alternate d unit would be most ent #64 and would protect Administrative Nurse #1 of any resident's being 64 and stated he was on a closely monitored to #2 on 5/18/12 at 1:25 PM esident #64 hit resident #173 een asked by the Social if they had a bed available vior Center. She stated that at #64 was not a candidate as were not due to a mental cial Worker (SW) on 5/18/12 that room changes had been residents. When it was dent #173 had been acknowledged this was still as one of the reasons they the placement for Resident the residents Responsible tant to agree to placement in finally agreed. The SW said me to the facility to assess the end neither would admit the was sent out to the the but was returned without SW added that the facility	L.	323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345286	B. WIN	3		05	/19/2012
NAME OF PROVIDER OR SUPPLIER SALISBURY CENTER				710 J	ADDRESS, CITY, STATE, ZIP CODE ULIAN ROAD SBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC (DENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 323	this time she had no Resident # 64. She a meantime the facility other residents. During interview with 11:50 he indicated the Resident #64's medic his aggressive behave placement was need would take some time work and that the staclosely to redirect hin acknowledged that Resident #173 but have aggressive behave aggressive behave aggressive behave acknowledged 1:1 residents like him wo and indicated his supersidents on 1:1 as no residents. He also no be done as a Nursing. The facility provided Allegation of Complian Credible Allegation of Complian Credible Allegation of Resident #64 immed supervision by nursing 5-18-12 @ approximately 12:00 resident to Geriatric Resident t	discharge options for acknowledged that in the was responsible to protect the Physician on 5/19/12 at at he had made changes to cations to try and manage ior and that alternate ed. He also stated that it is for medication changes to ff monitored the resident in. The physician esident #64 continued to aviors particularly against ad thought that 1:1 staffing he facility to do. However, staffing for resident #64 or aid protect other residents port for the facility placing eeded to protect other oted that 1:1 staffing could a Order. In acceptable Credible and Director notified @	F	323			

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345286		(X1) PROVIDER/SUPPLIER/CLIA	I	IULTIP LDING	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		B. WIN	1G		05/19/2012		
NAME OF PROVIDER OR SUPPLIER SALISBURY CENTER				7	EET ADDRESS, CITY, STATE, ZIP CODE 10 JULIAN ROAD ALISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION DATE
F 323	interviewing all reside assess feelings of sa complete by 5/19/12. Administrator/DON for action as needed. Others with Potential Any resident identifie aggressive behavior immediately be place nursing personnel/de re-educated immediately behaviors and complementary will be notified of any nursing supervisor/de immediately. Non-minumediately. Non-minume	ric Behavior Unit @ bm. Social will immediately begin ents/family members to fety within Center and Findings will be reported to brimmediate corrective to be Affected d by any staff demonstrating to other residents will d on 1:1 supervision by signee. All staff will be tely/continuously by the esignee on aggressive eted by 5/19/12. Physician aggressive behaviors by esignee by telephone edication related intervention creation Director/designee ector of Nursing/licensed t any physician ogical intervention upon mic Changes was consulted via email on regarding residents with Eacility received training ggressive behaviors on All staff including and ancillary will be ctor of Nursing/designee on behaviors	F	323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345286	B. WIN	G		05/1	9/2012
	OVIDER OR SUPPLIER			7'	EET ADDRESS, CITY, STATE, ZIP CODE 10 JULIAN ROAD ALISBURY, NC 28147		
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 323	Continued From page	26	F	323			
	to identify any aggres across all 3 shifts dail times a week across all 3 shifts dail times a week across a Monitoring tool for agg behavior was develop includes observation inappropriate/aggress the behavior and interconducted by Director to date care plans for behaviors. Presently, services through ACT inappropriate/aggress for other mental health physician. Interdiscip discuss/address all be implemented with effer Findings will be report trends with corrective 60 days (7-17-12). The credible allegation 12:10 PM, as evidence managing aggressive for 1:1 observation, reresidents with behavior tracking and care plar log for resident and fafeeling safe, and intermembers about feelin Resident #64 had been 5/18/12 at 10 " 55 Jan 20 and 10 to 1	rive behaviors, triggers for eventions. An audit will be of Nursing/designee for up anyone with documented facility offers mental health S for residents with sive behaviors or as needed in needs as determined by linary Team will ehaviors and interventions activeness as needed. The dealth of the committee for action taken as needed for the was verified 5/19/12 at ed by staff interviews on behaviors and the option eviewing care plans for ors, reviewing behavior in audits, reviewing facility					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SUR COMPLETI		
	345286		B. WING			05/19/2012		
NAME OF PRO	VIDER OR SUPPLIER			716	EET ADDRESS, CITY, STATE, ZIP CODE 0 JULIAN ROAD ALISBURY, NC 28147			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	the audits were compourrently in the facility. The audits were compoured in the facility and 1st shift were identified. The for tracking type of beinterventions and the and wandering care I these 10 residents ar 5/18/12. Review of the inserving information on Aggre Dementia, Causes, Management of Acut Important Tips and the Problem Behaviors of written notation "any staff 1:1 and notify placereation for non-ph" All nursing staff prwell as multiple anciling were interviewed and inservice before start to explain what they aggressive behaviors staffing. Review of the facility interviews revealed all residents or family safe. Multiple reside	or tracking Forms revealed eleted on all 10 residents with identified behaviors. pleted on 2nd and 3 rd shift 5/19/12 and no behaviors tracking form had columns ehavior, triggers and ir effectiveness. Behavior Plans were also reviewed for and updated as needed on the ce materials revealed the ssive Behaviors in	L.	323				

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					. 0938-0391
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			ÆY D
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		DING		COMPLETED	
	345286 B. WING			05/19	/2012		
NAME OF PR	OVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
SALISBUR	RY CENTER			\$) JULIAN ROAD LISBURY, NC 28147		
					PROVIDER'S PLAN OF CORRECT	TION	(X5) COMPLETION
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
F 323	at 11:46 revealed he providing non-pharm interventions for resi	ecreation Director on 5/19/12 r department's role in acological divisional	F	323			

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Event ID: 2NQS11

Facility ID: 923354

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		I AND HUMAN SERVICES & MEDICAID SERVICES		FOR	D: 08/19/2012 M APPROVED D. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION (X3) DATE COMP	SURVEY LETED
		345286	B. WING	SEP 0 4 2013	16/2012
NAME OF F	PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE	
SALISBU	JRY CENTER			O JULIAN ROAD ALISBURY, NO 28147	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ! (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) .	(X6) COMPLETION DATE
K 000	INITIAL COMMENT	rs	K 000	Light fixture that was	
	This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications, This building is Type III protected			blocking sprinkler head in the dietician's office will be moved by Maintenance Director by 8/29/2012. Maintenance	8/29/2012
	system arrangemen The facility is equipt sprinkler system.	utilizing a delayed locking at on two doors in the facility. bed with an automatic		Director/designee will perform an audit by 8/29/2012 and then quarterly x 1 year to identify any sprinkler heads that are blocked	
		FETY CODE STANDARD	K 056	with corrective action taken as needed.	
	installed in accordar for the Installation of provide complete co- building. The syster accordance with NF Inspection, Testing, Water-Based Fire P supervised. There is supply for the syster systems are equipped	atic sprinkler system, It is not with NFPA 13, Standard of Sprinkler Systems, to overage for all portions of the m is properly maintained in PA 25, Standard for the and Maintenance of rotection Systems. It is fully see a reliable, adequate water m. Required sprinkler ed with water flow and tamper electrically connected to the yetem. 19.3.5		Findings will be reported to the Administrator. All trends will be taken to the monthly QA committee for continued quality improvement.	-
	Based on the obser on August 16, 2012 observed as noncon include:	not met as evidenced by: vations and staff interviews following Life Safety Item was npllant, specific findings			
ABORATORY	DIRECTOR'S OR PROVIDE	EVSTPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE . Administratur	(X8) DATE タ/ファ/レン

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER AND PLAN OF CORRECTION IDENTIFICA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G 01 - MAIN'BUILDING 01	(X3) DATE SURVEY COMPLETED			
		345286	B. WING_		08/	16/2012		
	PROVIDER OR SUPPLIER URY CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMP				
K 056	Continued From pa The sprinkler head outside the dietary of the light fixture in th	in the dieticlans office just department was blocked by	K 056					
	CFR#: 42 CFR 483	3.70 (a)		•				
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Event ID: 2NQS21

Facility ID: 923354

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